KAISER PERMANENTE®

Northern California

☐ **Psychiatry**

MR #: ____________________

Name: ____________________

IMPRINT AREA

ADULT PERSONAL DATA SHEET

☐ Antioch ☐ Martinez ☐ Pleasanton ☐ Walnut Creek

ENCOUNTER DATE	PROVIDER: FIRST NAME, LAST NAME		
NAME			MEDICAL RECORD #
ADDRESS			CITY / ZIP
HOME PHONE			WORK PHONE
AGE	SEX	BIRTHDATE	PLACE OF BIRTH
EMERGENCY CONTACT			PHONE
REFERRED TO THIS CLINIC BY:			MILITARY SERVICE
OCCUPATION			HOW LONG ON PRESENT JOB
EMPLOYER			USUAL WORK HOURS
HOW LONG HAVE YOU LIVED IN THIS AREA?			LAST SCHOOL GRADE COMPLETED
CHECK ONE: ☐ Married/Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed			
LIVING WITH SPOUSE/PARTNER: ☐ Yes ☐ No			NUMBER OF YEARS
ETHNICITY			RELIGION

Do you have a work-related problem? ☐ Yes ☐ No

Are you currently on:

a) Workers' Compensation? ☐ Yes ☐ No

b) SSI? ☐ Yes ☐ No

c) State Disability? ☐ Yes ☐ No

Do you want to initiate a Workers' Compensation or disability claim at your appointment? ☐ Yes ☐ No

TYPE(S) OF HELP DESIRED:

☐ Medication Therapy ☐ Counseling/Therapy ☐ Substance Use/Abuse Treatment

☐ Group Counseling ☐ Family Counseling ☐ Couples Counseling ☐ Other: ____________

1. Major reason(s) for seeking help at this time: ____________________

2a. How long have you had these problems or symptoms? ____________________

2b. How often do they occur? ____________________

3. Why did you decide to seek help now? ____________________

4. What have you tried? ____________________

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5. Past Psychiatric Treatment

			Type (Individual/Family)?	By Whom?	Year?	Helpful? (Y/N)	
Counseling or Psychotherapy	**Yes**	**No**				**Yes**	**No**
			1.				
			2.				
			3.				
			4.				
			5.				

			Name of Medication?	By Whom?	Year?	Helpful? (Y/N)	
Psychiatric Medication(s)	**Yes**	**No**				**Yes**	**No**
			1.				
			2.				
			3.				
			4.				
			5.				
			6.				
			7.				

			Where?	Why?	Year?	Helpful? (Y/N)	
Psychiatric Hospital Admissions	**Yes**	**No**				**Yes**	**No**
			1.				
			2.				
			3.				
			4.				
			5.				
			6.				

6. Check items below that apply to your current and past condition(s):

	Current	Past		Current	Past		Current	Past
Headaches								
Dizziness			Restlessness			Hear voices others don't hear		
Stomach/bowel trouble			Decreased need for sleep			See things others don't see		
Health problems			Mood swings			Strange experiences		
Pain			Excess energy &/or feeling wired			Feel people plot against you		
Tremors or tics						Constant suspicion/distrust		
Drug &/or alcohol cravings			Confusion			Unusual thoughts		
Eating problems			Elated/euphoric mood			Someone physically harming you		
Binge eating			Excessive spending			Thoughts of physically harming someone else		
			Racing/overflow of thoughts			Violent/aggressive behavior		
Sleep problems			Irritable					
Weight loss			Impulsive behavior			Physical abuse		
Weight gain			Grandiose thoughts/plans			Sexual abuse		
Loss of appetite			Anger or explosiveness			Sexual problems		
Feeling apart from other						Relationship problems		
Low energy			Panic attacks					
Feeling worthless			Anxiety					

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6. continued . . .	Current	Past		Current	Past		Current	Past
Memory problems			Fears			Financial problems		
Thoughts of suicide			Nightmares			Conflict in family		
Planning suicide			Fears of losing self control					
Feeling depressed			Recurring unwanted thoughts/behaviors					
Crying a lot			Always worried					
Unable to have a good time			Concentration problems					

7. Do you have any serious or chronic medical conditions (including past surgeries) ☐ Yes ☐ No
   If yes, date(s) and details: ____________________

8. Do you have any serious medical accidents or injuries, head injury, or seizure history? ☐ Yes ☐ No
   If yes, date(s) and details: ____________________

9. Are you currently taking any medications (include over-the-counter and herbal)? ☐ Yes ☐ No
   If yes, please list: ____________________

10. Have you had any allergic reactions to, or other problems with medications? ☐ Yes ☐ No
    If yes, details: ____________________

11. ALCOHOL AND OTHER DRUG USE:

A. Do you use alcohol? ☐ Yes ☐ No
   How much per day/week? __________ Age when you started drinking? __________
   Last drink taken (time and amount): ____________________

B. Do you use other drugs? ☐ Yes ☐ No
   What kind? ____________________
   How much? ____________________
   Age you started using? ____________________
   Last drug use (time and amount): ____________________

C. Do you feel you have a problem with:
   Alcohol ☐ Yes ☐ No
   Other drugs ☐ Yes ☐ No
   If so, explain: ____________________

D. Previous treatment programs (list dates and locations, if possible): ____________________

E. Has your drinking/drug use caused problems in the family or with your relationships? ☐ Yes ☐ No

F. Caused problems on your job? ☐ Yes ☐ No

G. Is it difficult for you to stop or control the amount you take? ☐ Yes ☐ No

H. Have you ever been arrested for a D.U.I. (driving under the influence) or ☐ Yes ☐ No
   other drug related offense(s)? ☐ Yes ☐ No
   If so, when? ____________________

I. Have you ever used tobacco products? ☐ Yes ☐ No
   What kind and how much? ____________________
   When did you start? ____________________
   When did you stop? ____________________
   Did you use a program to stop? (please describe) ____________________

J. How many cups of caffeinated beverage(s) do you drink per day? (coffee, tea, colas, chocolate):
   ____

continued on next page

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12. Have you had any financial problems, legal difficulties/problems or previous imprisonment? ☐ Yes ☐ No
    If yes, dates and details: ______

13. Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? ☐ **Yes** ☐ **No**

Relative	Symptoms / Problems	Treatment	Psychiatric Medications	Psychiatric Hospitalizations

14. Have any family members had problems with criminal offenses, been in jail/prison? ☐ Yes ☐ No
    If yes, who, why? ______

15. FAMILY DATA

Name	City Residence	Check (✔) if living with you	If living, age	If deceased age at, and year of death	Occupation	How do/did you get along
Spouse/Partner						
Children						
Father						
Stepfather						
Mother						
Stepmother						
Siblings/Step Siblings						
Others in household						

PATIENT SIGNATURE ______ DATE ______

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CONFIDENTIALITY DISCLOSURE

☐ Antioch ☐ Martinez ☐ Pleasanton ☐ Walnut Creek

ENCOUNTER DATE	PROVIDER: FIRST NAME, LAST NAME

KPNC's Mental Health and Chemical Dependency Services: Your Right to Privacy

Separation of Records

Kaiser Permanente's Mental Health and Chemical Dependency (MH/CD) services are strongly committed to protecting your privacy. The Northern California Notice of Privacy provides general information about how your medical information is used and protected. Federal and state law protects the confidentiality of your records. Violation of federal confidentiality laws related to chemical dependency programs is a crime. Suspected violations may be reported to the appropriate authorities.

Except under limited circumstances (see examples below), Kaiser Permanente's MH/CD program may not, without your written permission, disclose information about your care to anyone outside of Kaiser Permanente. For your privacy, records of your MH/CD visits are kept separate from your outpatient medical record except that: for your personal safety, any medications or related laboratory results that have been prescribed as part of your MH/CD treatment are included in your medical record, either on paper or electronically. Mental Health diagnoses are only available to treating providers on a need-to-know basis.

Coordination of Care

Because MH/CD staff work as members of an integrated system of care, relevant information about your care will be exchanged among MH/CD staff as necessary. Your permission is not required to coordinate your psychiatric care with care providers within Kaiser Permanente, such as your primary care doctor. However, ordinarily we will discuss with you any necessary sharing of psychiatric information. When we share information, we only share that information which, in our professional judgment, we believe is needed for appropriate medical care by that provider. Your written authorization is normally required before any information about chemical dependency treatment can be released to anyone outside the MH/CD treatment team. A valid written authorization must specify the nature of the information to be released, identify the receiving party, and indicate when your authorization expires.

Exceptions to Confidentiality Rules

Examples of circumstances under which the law requires or permits us to release information, without your permission, include:

- medical and psychiatric emergencies in which the information is essential to an individual's safety
- disclosures of information to warn potential victims of violent acts
- to qualified personnel for audit or program evaluation or research. For example, you may receive surveys from persons authorized by Kaiser Permanente to conduct surveys on its behalf.
- reporting of suspected child abuse or neglect
- to report the commission of crimes on our premises or against our program personnel
- responses to court orders in which a judge has ruled that the information is necessary for the administration of justice (42 U.S.C. Section 290dd-2 for Federal laws and 42 C.F.R. Part 2 for Federal regulations)
- reports to the Department of Motor Vehicles due to lapses of consciousness

If at any time you have concerns about your privacy, you are encouraged to request clarification from your therapist or a staff member.

Acknowledgment:

By signing your name in the space below, you acknowledge that you have read and understood this document. *(Note: If the person receiving care is a minor, then a parent or legal guardian acknowledges having read and understood this document. Under certain circumstances, minors may consent to treatment themselves without parental permission.)*

PATIENT'S SIGNATURE (IF SIGNATURE OTHER THAN PATIENT, LIST RELATIONSHIP)	DATE
WITNESS' SIGNATURE	DATE

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Name: ____________________

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CONSENT TO TREATMENT

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Consent to Treatment

Most people who participate in behavioral or mental health treatment benefit from it. Like most kinds of health care, this kind of treatment requires a very active effort on your part if you are going to get something out of it. In addition, there may be certain kinds of risks involved. For example, the therapy process can be challenging and sometimes may involve experiencing some uncomfortable feelings, or engaging in difficult interactions, or facing difficult aspects of your life. Nevertheless, most people find the benefits outweigh any such risks. In fact, sometimes there can be more risks associated with **not** participating in therapy.

If you see a physician as part of your care, he or she may prescribe medication for you. If so, you'll be advised at that time of the benefits and any risks of the medications.

It is important that you participate in this treatment willingly. If you have any questions or concerns about this document, about the services being provided to you, or about your treatment options, you should definitely ask your therapist.

Acknowledgment

By signing your name in the space below, you are acknowledging that you have read and understood this document and that you voluntarily agree to participate in this treatment. *If the person receiving care is a minor, a parent or legal guardian acknowledges having read and understood this document and voluntarily agrees to the minor's participation in the treatment (except in certain legally exempt situations).*

PATIENT'S SIGNATURE (IF SIGNATURE OTHER THAN PATIENT, LIST RELATIONSHIP)	DATE
WITNESS' SIGNATURE	DATE